

PRINTED: 10/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185389	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  R 10/14/2010
NAME OF PROVIDER OR SUPPLIER  EDGEMONT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
(F 000)	INITIAL COMMENTS	(F 000)			
(F 371) SS=E	<p>A revisit survey was conducted 10/13/10 through 10/14/10. The facility was found to be in compliance with all areas except 483.35 Sanitary conditions (F371 Dietary Sanitation) and 483.75 Quality Assessment and Assurance (F520 Quality Assurance) related to Dietary Sanitation.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility policy, it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. Observations on 10/13/10 revealed one (1) half size hotel pan wrapped with aluminum foil, labeled Salmon. Holes were observed in the aluminum foil wrapping covering the food, exposing the food to the bottom of a container of cookies sitting on top of the foil. Additional observations included frozen turkey thawing in the refrigerator sitting directly on top of the eggs, and a plastic bag containing staff food items and staff soft drinks stored in the refrigerator. Pans were observed to be stored wet, the meat slicer was stored dirty, and plate covers and trays were stored dirty. Staff were</p>	(F 371)			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Deborah Zeel*

TITLE

*Administrator*

(X6) DATE

11/1/10

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 371}	<p>Continued From page 1</p> <p>observed washing dishes, and failed to clean the dishwasher basket, as instructed.</p> <p>The findings include:</p> <p>1. Observation during initial tour on 10/13/10 at 12:52 PM revealed a half size hotel pan labeled salmon wrapped with aluminum foil and stored in the refrigerator with a box of sugar cookies stored on top of the aluminum foil. Observation revealed the aluminum foil was torn in large areas exposing the salmon to the bottom of the sugar cookies cardboard container.</p> <p>Interview with the Dietary Manager on 10/13/10 at 1:05 PM revealed the salmon should not have been stored in this manner because the food should be covered when stored in the refrigerator.</p> <p>2. Observation on 10/13/10 at 12:57 PM revealed a frozen turkey thawing in a hotel pan, which was sitting directly on top of a cardboard container of pasteurized eggs.</p> <p>Interview with the Dietary Manager on 10/13/10 at 1:05 PM revealed she did not think there was a problem because the turkey was in the deep pan, and the turkey was a fully cooked turkey.</p> <p>3. Observation on 10/13/10 at 12:57 PM revealed two (2) bottled soft drinks, which had been opened, and were approximately half full, stored in the refrigerator with a plastic grocery bag containing food items.</p> <p>Interview with the Dietary Manager on 10/13/10 at 1:05 PM revealed the soft drinks were staff drinks and the grocery bag contained cookies and pepperoni that belonged to a kitchen staff</p>	{F 371}			

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{F 371}	<p>Continued From page 2</p> <p>member. She further indicated the Registered Dietitian at the facility had told her it was okay for staff to store soft drinks in the refrigerator as long as the drinks had a lid.</p> <p>4. Observation on 10/13/10 at 1:13 PM revealed one (1) half size deep hotel pan, one (1) half size hotel pan and one (1) deep hotel pan stored wet.</p> <p>Interview with Dietary Aide #1 on 10/13/10 at 1:13 PM revealed the Aide was aware the pans should not have been stored wet. Observation, at the time, revealed the Dietary Aide did not remove the pans, or rewash them. The pans continued to be available for use.</p> <p>Interview with the Dietary Manager on 10/13/10 at 1:13 PM revealed she was unaware the pans should not be stored wet.</p> <p>5. Observation on 10/13/10 at 1:25 PM revealed the meat slicer was stored with particles of a light tan color located around the holding spikes that hold meat in place on the slicer, and crumbs were observed on the slice catching surface and around the blade.</p> <p>Interview with the Dietary Manager on 10/13/10 at 1:30 PM revealed the meat slicer did appear to have particles of food on it and it should be cleaned and sanitized after each use.</p> <p>6. Observation on 10/13/10 at 1:28 PM revealed fifteen (15) plate covers stored wet with multiple food particles observed on the covers. Seven (7) individual serving bowls were stored wet, four (4) trays were stored wet with multiple food particles observed on the trays. Staff were observed to be running dishes through the dish washer, at the</p>	{F 371}			

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{F 371}	<p>Continued From page 3</p> <p>time, and were observed to continue to place dishes and trays in storage that were wet and/or had food particles adhered.</p> <p>Interview on 10/13/10 at 1:30 PM with the Dietary Manager revealed the plate covers, bowls and trays should not be stored wet, with food particles adhered to the dishes.</p> <p>Interview on 10/13/10 at 2:30 PM with the Executive Director revealed the company who repaired the dishwasher had been called related to dishes coming out of the dishwasher with food particles remaining on them.</p> <p>Interview on 10/13/10 at 2:40 PM with the Dietary Manager revealed she was unaware the dishwasher was not cleaning the food particles from the dishes.</p> <p>Interview on 10/14/10 at 11:08 AM with the Executive Director revealed she had been notified the rinse blade on the dishwasher needed to be replaced. In addition, staff had been instructed to clean the food particles out of the basket on the bottom of the dishwasher to keep the food particles from collecting on the cleaned dishes.</p> <p>Interview on 10/14/10 at 12:15 PM with Dietary Aide #2 revealed the staff were aware that dishes would sometimes come out of the dishwasher with food particles on them. The Dietary Aide stated she was not sure how long this had been occurring and did not recall it being reported.</p> <p>Observation on 10/14/10 from 11:50 AM through 12:18 PM revealed the facility ran the dishwasher through five cycles during the lunch meal service. Observation revealed food particles in the basket</p>	{F 371}			

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{F 371}	Continued From page 4 inside the dishwasher with no staff observed to clean the basket on the dishwasher.  Interview with the Dietary Manager on 10/14/10 at 12:30 PM revealed while the facility was waiting for parts to arrive the basket in the bottom of the dishwasher should be cleaned every four cycles. She further indicated there were only four (4) trays in use to put items through the dishwasher and after the fourth tray the staff was to clean the basket before washing more dishes.  Review of the facility's policy related to dish washing revealed all dishes should be allowed to air dry, and after dishes were dry, they should be checked for cleanliness of each dish. The clean, dry dishes should then be placed in the storage area. The policy further stated all dirty dishes must be put back in the dishwasher.	{F 371}			
{F 520} SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.  The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.  A State or the Secretary may not require disclosure of the records of such committee	{F 520}			

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{F 520}	<p>Continued From page 5</p> <p>except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure the Quality Assurance Program was effective in developing and implementing appropriate plans of action to correct identified quality deficiencies related to 483.35, Dietary Sanitation.</p> <p>The findings include:</p> <p>Based on observation, interview and review of facility policy, it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. Observations on 10/13/10 revealed one (1) half size hotel pan wrapped with aluminum foil, labeled Salmon. Holes were observed in the aluminum foil wrapping covering the food, exposing the food to the bottom of a container of cookies sitting on top of the foil. Additional observations included frozen turkey thawing in the refrigerator sitting directly on top of the eggs, and a plastic bag containing staff food items and staff soft drinks stored in the refrigerator. Pans were observed to be stored wet, the meat slicer was stored dirty, and plate covers and trays were stored dirty. Staff were observed washing dishes, and failed to clean the dishwasher basket, as instructed.</p>	{F 520}			

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{F 520}	<p>Continued From page 6</p> <p>Review of the facility's Plan of Correction for deficiencies cited during the 7/15/10 annual survey, revealed the Dietary Manager was to assure general sanitation requirements were being met. Further review of the facility's Plan of Correction revealed an assigned Department Manager was to inspect the Dietary Department weekly and document findings on audit sheets. Interview with the Department Manager on 10/14/10 at 2:10 PM, revealed these audit sheets were reviewed during the weekly Quality Assurance meetings. However, review of the documentation on the audit sheets revealed no specific information as to what was being inspected, only "kitchen/basement".</p> <p>Interview with the Dietary Manager on 10/14/10 at 3:40 PM revealed she completed audits on the concerns previously cited during the Standard Survey. She stated she was specifically reviewing issues cited during the Standard Survey. She further stated there was no audit to ensure dishes were clean, and stored clean and dry. Further interview revealed she was not aware of any problems with the dishwasher or the storage of dirty dishes.</p> <p>Interview with the facility's Registered Dietitian on 10/14/10 at 3:45 PM revealed her role in the Quality Assurance process was to provide inservice training for staff, related to deficiencies cited during the Standard Survey. She further indicated she specifically included deficiencies cited on the annual survey, and reviewed basic sanitation practices in these inservices. She further stated she had not addressed the storage of dishes. Interview further revealed the Dietitian completed sanitation audits monthly, however if</p>	{F 520}			

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{F 520}	<p>Continued From page 7</p> <p>patient care issues were identified, sometimes was unable to complete the monthly inspection.</p> <p>Interview with the Executive Director on 10/14/10 at 3:30 PM, revealed the concerns identified on October 13, 2010, related to food, equipment, and dish storage in the kitchen were part of Quality Assurance, in general, and were standards that should be monitored consistently. She further stated audits and inspection reports were reviewed weekly in the Quality Assurance meetings. However, the Quality Assurance Committee had not identified any quality issues related to dietary sanitation.</p> <p>Interview on 10/14/10 at 2:10 PM, with the Department Manager assigned to inspect the Dietary Department weekly, as part of Quality Assurance, revealed she went into the kitchen and "spot checked", and had not identified any major issues. She stated any issues identified were brought to the attention of Dietary Staff, and the identified issues corrected at the time. Interview further revealed she had not identified any problems with the dishwasher or dishes being stored wet, or dirty.</p>	{F 520}			

## **Plan of Correction: Ftag 371- Dietary Food Storage/Sanitation**

### **No sampled residents**

#1- All areas as noted in 2567 have been cleaned/corrected as of compliance date by dietary staff and manager including proper storage of foods in refrigerator, only food for residents allowed in refrigerators, dishes cleaned/dried appropriately before storing, dishwasher repaired that had problems beginning that day from blades not working correctly and parts arrived 10/16/10, equipment being cleaned per policy (between uses) as of 10/14/10. Ongoing weekly "audits by other QI members performed in addition to Dietary manager/dietician" to assure compliance maintained for all the above and documented on inspection form which is given to administrator/designee for review. Dietitian also informed as of 10/14/10 and is completing QA audit for all aspects of sanitation/F371 with every visit in addition to administration audit rounds to assure compliance. (see below for specific auditing information under #3). Dietary staff inserviced- regarding all aspects of Fed. Regulations along with QI members performing in depth inspections as described above ongoing and have assured compliance with every issue as noted in 2567 in addition to general sanitation, food storage, etc.

#2- No other areas identified as facility only has one kitchen and audits/inspections include checklist of additional sanitation concerns in addition to ones noted in 2567 completed by Dt manager, dietician, designated QI Dept heads/administration monitoring for all sanitation, storage, etc and noted on audit forms as of 10/15/10. No residents have been adversely affected by said practice as evidenced by no outbreaks in illness, and no additional issues noted after 1<sup>st</sup> day of survey as dietary manager/administration addressed concerns prior to survey exit. Only one dishwasher which company came to fix on 10/13/10 and parts arrived/fixed on 10/16/10. *It was recommended to wash basket out every 4 cycles during that time- not policy for ongoing or previous needs but during this period only.*

#3 and #4- Auditing schedule updated by Administrator/Executive Director to include additional aspects for compliance as of 10/15/10. Ftag 371 and F520, new audit forms to be completed by designated management team in addition to dietary manager and dietitian discussed at QA meeting held on 10/15/10 in addition to QA meeting held following week. New employee who was quoted in 2567 (not knowing how long dishwasher issues occurred along with not properly cleaning between cycles, etc. no longer employed and quit after being reminded of policies, reading requirements for Federal/State regulations). Responsible dietary staff received appropriate coaching sessions from non-compliance of known requirements as multiple inservices were previously given, aware of sanitation/food prep, etc. on 10/15/10 to prevent non-compliance from reoccurring. Any noted issues while designated management performing oversight with audits for assuring clean/dry dishes, not storing foods appropriately in refrigerator, cleaning equipment between uses, etc. will receive additional instructions at that time in addition to further inservicing/and disciplinary action if repeating issues after being informed.

In addition to Dietary manager assuring general sanitation requirements being met on daily basis, assigned Dept managers to perform inspections at least 5 times weekly and shall document on inspection check list of performing audit/and then note concerns on QA log for administrator/designee to address accordingly times 90 days. Dietitian shall perform in depth inspection while in facility times 60 days as part of QA compliance. This information shall be included with QA meeting as noted below times 90 days.

- Inservices Included Given by Administrator/ Corp. Executive Director on 10/14/10 and 10/15/10 to dietary manager/dietary staff which addressed Ftags 371 and F520 compliance assurance as well as specific deficiencies noted by survey team.
- Dept. Heads (QI administration)- inserviced by Administrator/C.E.D. on 10/14/10 and 10/15/10 regarding new audit forms, responsibilities for completing thorough inspections and overview of regulations for sanitation/storage/F371 and F520 and policies to monitor for training employees and documentation requirements to be discussed with QA meetings/administration, etc. Designated dept. heads given assignment schedule as well as weekend manager on duty and shall be alternated for assuring additional compliance in addition to dietary manager.
- QA meeting included inservice initiated on 10/15/10 to inform QA members, Medical Director, and Dietary manager of issues discussed at survey exit, gave/inserviced all information in Ftag 371 and F520 to assure entire regulation requirements addressed, and plan of correction already completed and what to continue to assure compliance (audits, dish washer being repaired, responsibilities, and expectations of dietitian while at facility for additional inspections, retraining of staff and actions taken and when additional QA meetings and inservices to repeat information and examine outcomes are scheduled.

QA meeting held 10/15/10 (as described above) and repeated on 10/27/10 to reveal compliance has been assured. Facility to conduct on monthly basis times 90 days to include information regarding survey, system protocols and prevention, and outcomes. Formal QA meetings shall return to quarterly basis thereafter.

**Dietary Manager responsible for compliance**

**Date of compliance: 10/18/2010**

### **Plan of Correction for F520- QA committee**

#### **Based on Non sampled residents for Dietary Sanitation/Storage concerns**

#1 and #2- All areas affecting F371 for Dietary Sanitation/Storage and requirements for assuring all aspects of dietary regulations are being addressed with quality assurance have been identified, corrected, and inservices, audits, repairs, and monitoring have been corrected and initiated prior to survey exit and completed by 10/18/10. Will continue with repeating inservices, audits, and QA meetings thereafter as scheduled and additional interventions will be done based on non-compliance, new employees, and no new issues have been identified as well as compliance of all issues as noted in 2567 have been corrected by 10/18/10 as facility utilized both survey exit information as well as entire F371 regulation to assure compliance with overall regulation. No residents were adversely affected by said practice as no outbreaks in illnesses, etc were noted both prior to and as of compliance date.

#3 and #4 Executive Director/Administrator will continue to assure compliance by completing/assuring audits/monitoring and training are completed per Plan of correction on weekly basis as well as with formal QA meetings/process that shall be done monthly times 90 days which will include discussing inservices, audit outcomes, and any non-compliance issues to QA team/dietary manager, and medical director along with other QI/QA members responsible for monitoring compliance. Facility has conducted many inservices, QA meetings, and audits that focused on said practices prior to revisit and changed to include additional aspects of prevention and interventions including adding additional checks by having other QA members perform more frequent audits/inspections, dietitian to perform thorough inspection with every visit (approximately 2 times monthly) in addition to dietary manager and same people performing audits to have different people inspecting after being given information for dietary regulations as of 10/15/10 to be able to perform inspections in detail. Please refer to F371 regarding specifics for sanitation/dietary interventions specifically. Audits will be performed at least 5 times weekly by different designated QI members who have been trained/inserviced on both the Fed/state regulations to perform in depth inspections that will be included with formal QA meetings. In addition dietary staff/manager were inserviced starting on 10/14/10, 10/15/10 and repeated following week in addition to being trained/inserviced while QI members/Dt manager monitoring cleaning, washing, food storage at that time.

In addition to 10/15/10 QA meeting which included deficient practice and discuss other possible complications, resolving current issues and auditing for compliance with both QA team and Medical Director/Administrator present, facility conducted another QA meeting on 10/27/10 and shall repeat monthly thereafter times 90 days These formal meetings are in addition to the weekly informal quality assurance performed by QA team to gather information for meetings. Even though F371 was not cleared in first revisit, facility had corrected specifics as previously mentioned and things cited for revisit where of new onset and not ongoing as evidence by previous survey, but facility will continue to monitor entire aspects of F371 when performing audits, inservices, checklists, etc. as described in F371.

**Dietary Manager and Administrator responsible for QA compliance**

**Date of compliance: 10/18/2010**

## Plan of Correction: Ftag 371- Dietary Food Storage/Sanitation

### No sampled residents

#1- All areas as noted in 2567 have been cleaned/corrected as of compliance date by dietary staff and manager including proper storage of foods in refrigerator, only food for residents allowed in refrigerators, dishes cleaned/dried appropriately before storing, dishwasher repaired that had problems beginning that day from blades not working correctly and parts arrived 10/16/10, equipment being cleaned per policy (between uses) as of 10/14/10. Ongoing weekly "audits by other QI members performed in addition to Dietary manager/dietician" to assure compliance maintained for all the above and documented on inspection form which is given to administrator/designee for review. Dietitian also informed as of 10/14/10 and is completing QA audit for all aspects of sanitation/F371 with every visit in addition to administration audit rounds to assure compliance. (see below for specific auditing information under #3). Dietary staff inserviced- regarding all aspects of Fed. Regulations along with QI members performing in depth inspections as described above ongoing and have assured compliance with every issue as noted in 2567 in addition to general sanitation, food storage, etc.

#2- No other areas identified as facility only has one kitchen and audits/inspections include checklist of additional sanitation concerns in addition to ones noted in 2567 completed by Dt manager, dietitian, designated QI Dept heads/administration monitoring for all sanitation, storage, etc and noted on audit forms as of 10/15/10. No residents have been adversely affected by said practice as evidenced by no outbreaks in illness, and no additional issues noted after 1<sup>st</sup> day of survey as dietary manager/administration addressed concerns prior to survey exit. Only one dishwasher which company came to fix on 10/13/10 and parts arrived/fixed on 10/16/10. *It was recommended to wash basket out every 4 cycles during that time- not policy for ongoing or previous needs but during this period only.*

#3 and #4- Auditing schedule updated by Administrator/Executive Director to include additional aspects for compliance as of 10/15/10. Ftag 371 and F520, new audit forms to be completed by designated management team in addition to dietary manager and dietitian discussed at QA meeting held on 10/15/10 in addition to QA meeting held following week. New employee who was quoted in 2567 ( not knowing how long dishwasher issues occurred along with not properly cleaning between cycles, etc. no longer employed and quit after being reminded of policies, reading requirements for Federal/State regulations). Responsible dietary staff received appropriate coaching sessions from non-compliance of known requirements as multiple inservices were previously given, aware of sanitation/food prep, etc. on 10/15/10 to prevent non-compliance from reoccurring. Any noted issues while designated management performing oversight with audits for assuring clean/dry dishes, not storing foods appropriately in refrigerator, cleaning equipment between uses, etc. will receive additional instructions at that time in addition to further inservicing/and disciplinary action if repeating issues after being informed.

In addition to Dietary manager assuring general sanitation requirements being met on daily basis, assigned Dept managers to perform inspections at least 5 times weekly and shall document on inspection check list of performing audit/and then note concerns on QA log for administrator/designee to address accordingly times 90 days. Dietitian shall perform in depth inspection while in facility times 60 days as part of QA compliance. This information shall be included with QA meeting as noted below times 90 days.

- Inservices Included Given by Administrator/ Corp. Executive Director on 10/14/10 and 10/15/10 to dietary manager/dietary staff which addressed Ftags 371 and F520 compliance assurance as well as specific deficiencies noted by survey team.
- Dept. Heads (QI administration)- inserviced by Administrator/C.E.D. on 10/14/10 and 10/15/10 regarding new audit forms, responsibilities for completing thorough inspections and overview of regulations for sanitation/storage/F371 and F520 and policies to monitor for training employees and documentation requirements to be discussed with QA meetings/administration, etc. Designated dept. heads given assignment schedule as well as weekend manager on duty and shall be alternated for assuring additional compliance in addition to dietary manager.
- QA meeting included inservice initiated on 10/15/10 to inform QA members, Medical Director, and Dietary manager of issues discussed at survey exit, gave/inserviced all information in Ftag 371 and F520 to assure entire regulation requirements addressed, and plan of correction already completed and what to continue to assure compliance (audits, dish washer being repaired, responsibilities, and expectations of dietitian while at facility for additional inspections, retraining of staff and actions taken and when additional QA meetings and inservices to repeat information and examine outcomes are scheduled.

QA meeting held 10/15/10 (as described above) and repeated on 10/27/10 to reveal compliance has been assured. Facility to conduct on monthly basis times 90 days to include information regarding survey, system protocols and prevention, and outcomes. Formal QA meetings shall return to quarterly basis thereafter.

**Dietary Manager responsible for compliance**

**Date of compliance: 10/18/2010**

**Plan of Correction for F520- QA committee**

**Based on Non sampled residents for Dietary Sanitation/Storage concerns**

#1 and #2- All areas affecting F371 for Dietary Sanitation/Storage and requirements for assuring all aspects of dietary regulations are being addressed with quality assurance have been identified, corrected, and inservices, audits, repairs, and monitoring have been corrected and initiated prior to survey exit and completed by 10/18/10. Will continue with repeating inservices, audits, and QA meetings thereafter as scheduled and additional interventions will be done based on non-compliance, new employees, and no new issues have been identified as well as compliance of all issues as noted in 2567 have been corrected by 10/18/10 as facility utilized both survey exit information as well as entire F371 regulation to assure compliance with overall regulation. No residents were adversely affected by said practice as no outbreaks in illnesses, etc were noted both prior to and as of compliance date.

#3 and #4 Executive Director/Administrator will continue to assure compliance by completing/assuring audits/monitoring and training are completed per Plan of correction on weekly basis as well as with formal QA meetings/process that shall be done monthly times 90 days which will include discussing inservices, audit outcomes, and any non-compliance issues to QA team/dietary manager, and medical director along with other QI/QA members responsible for monitoring compliance. Facility has conducted many inservices, QA meetings, and audits that focused on said practices prior to revisit and changed to include additional aspects of prevention and interventions including adding additional checks by having other QA members perform more frequent audits/inspections, dietitian to perform thorough inspection with every visit (approximately 2 times monthly) in addition to dietary manager and same people performing audits to have different people inspecting after being given information for dietary regulations as of 10/15/10 to be able to perform inspections in detail. Please refer to F371 regarding specifics for sanitation/dietary interventions specifically. Audits will be performed at least 5 times weekly by different designated QI members who have been trained/in serviced on both the Fed/state regulations to perform in depth inspections that will be included with formal QA meetings. In addition dietary staff/manager were inserviced starting on 10/14/10, 10/15/10 and repeated following week in addition to being trained/in serviced while QI members/Dt manager monitoring cleaning, washing, food storage at that time.

In addition to 10/15/10 QA meeting which included deficient practice and discuss other possible complications, resolving current issues and auditing for compliance with both QA team and Medical Director/Administrator present, facility conducted another QA meeting on 10/27/10 and shall repeat monthly thereafter times 90 days These formal meetings are in addition to the weekly informal quality assurance performed by QA team to gather information for meetings. Even though F371 was not cleared in first revisit, facility had corrected specifics as previously mentioned and things cited for revisit where of new onset and not ongoing as evidence by previous survey, but facility will continue to monitor entire aspects of F371 when performing audits, inservices, checklists, etc. as described in F371.

**Dietary Manager and Administrator responsible for QA compliance**

**Date of compliance: 10/18/2010**

# Edgemont Healthcare

## POLICY

It is the policy of this facility to properly sanitize dishes and to establish systems to avoid the improper handling of dishware.

## PROCEDURE

Proper sanitation of dishware and dishware equipment is essential to prevent the spread of illness from one resident to another. For dishes and storage equipment to be properly cleaned, dishes and equipment must be washed to remove visible dirt and sanitized to kill germs. Furthermore, it is essential that food service workers use proper technique to avoid re-contaminating sanitized dishes. Thus, it is essential to establish systems to avoid the improper handling of dishware.

### General Rules:

1. The person working in the dirty dish area cannot handle any of the clean dishes unless he/she washes hands thoroughly before handling. Contamination of clean dishes results from working with dirty and clean dishes without proper hand washing.
2. The person putting away clean dishes must have clean hands
3. Cleaned dishes cannot be towel dried as this can re-contaminate the dishware.
4. Cleaned dishes must be allowed to air dry before storage.

# Edgemont Healthcare

## POLICY

It is the policy of this facility to clean and sanitize pots and pans to maintain sanitary food preparation.

## PROCEDURE

1. Pots and pans may be cleaned using the dishwashing machine.
2. The three sink system is preferred if the dish washing machine is not used. For Three Sink System. Sink No 1. (Wash Sink) prepare a hot solution of facility approved cleaner, Sink No 2. (Rinse Sink) should be a clear, hot water rinse. Sink No. 3 (Sanitizing Sink), prepare a solution of the facility approved sanitizer and hot water.
3. If only two sinks are available, use Sink No. 1 for washing: Sink No. 2 for Sanitizing. For this arrangement, as ware is lifted out of Sink No. 1 it is flushed or sprayed with fresh water, then placed in Sink 2 for sanitizing.
4. The sanitizer of the pot/pan sink will be recorded three times a day.
5. The following process will be followed for manual dish washing of pots and pans.
6. Pre-soak/Wash. Scrape excess soil from ware.
7. Scrub all surfaces. Scrape excess soil from ware.
8. Immerse in Rinse Sink. Remove ware. Let excess water run back in Rinse Sink.
9. Immerse ware in Sanitizing Sink, following manufacturing instructions for sanitizer.
10. Remove from Sanitizing Sink and invert on drain board. Let air dry. Change water when it becomes cool or dirty.
11. Follow product label instructions use and concentrations.

### Policy:

Utensils and dishes washed by mechanical dishwasher will be clean.

### Procedure:

#### Dishwasher

- 1) Scrape food into the trash can or garbage disposal. Throw paper and disposable items in the trash can.
- 2) Pull out a tray from the service cart. Place silverware in container of soap water for soaking.
- 3) Wash other dishes by running them through the dishmachine.

#### Clean Dish Puller

- 1) Wash hands to ensure they are clean.
- 2) Allow all dishes to air dry.
- 3) Once dishes are dry check for cleanliness of each dish.
- 4) Place clean, dry dishes in proper storage area.
- 5) All dirty dishes must be put back in the dishwasher.

## **INVESTIGATIVE PROTOCOL**

### **SANITARY CONDITIONS**

#### **Objectives**

- To determine if the facility obtained food safe for consumption from approved sources;
- To determine if the facility stores, prepares, distributes, and serves food in a sanitary manner to prevent foodborne illness;
- To determine if the facility has systems (e.g., policies, procedures, training, and monitoring) in place to prevent the spread of foodborne illness and minimize food storage, preparation and handling practices that could cause food contamination and could compromise food safety; and
- To determine if the facility utilizes safe food handling from the time the food is received from the vendor and throughout the food handling processes in the facility.

#### **Use**

Use this protocol to investigate compliance at F371 (§483.35(i) (1) and (2)).

#### **Procedures**

Adhere to sanitary requirements (e.g., proper washing hands when entering the kitchen and between tasks, use of hair restraints) when assessing the kitchen and meal service throughout the survey process. During the initial tour of the facility and throughout the survey, observe the kitchen(s) and food service area(s) and review planned menus to determine when to assess food preparation processes. Observe subsequent kitchen/food services during times when food is being stored, prepared, cooked, plated, transported, and distributed to determine if safe food handling practices are being followed. Corroborate observations through interview, record review, and other appropriate documentation.

**NOTE:** When a facility receives food from an off-site kitchen (any kitchen not operated by the facility), determine whether the food was obtained from an approved source.

#### **1. Observation**

Conduct the following observations:

- Food procurement procedures:
  - Determine whether food meets safe and sanitary conditions related to when, where, and how the food was received for residents consumption.

- Observe stored dishes, utensils, pots/pans, and equipment for evidence of soiling. These items should be stored in a clean dry location and not exposed to splash, dust or other contamination; and
- Evaluate whether proper hand washing is occurring between handling soiled and clean dishes to prevent cross-contamination of the clean dishes.

#### **Storage of food:**

- Observe for evidence of pests, rodents and droppings and other sources of contamination in food storage areas;
- Observe food labeling and dates (e.g., used by dates);
- Observe that foods are stored off of the floor, and clear of ceiling sprinklers, sewer/waste disposal pipes and cleaning chemicals;
- Observe whether the facility has canned goods that have a compromised seal (e.g., punctures); and
- Observe whether staff access bulk foods without touching the food.

## **2. Interview**

During the course of the survey, interview the staff who performs the task about the procedures they follow to procure, store, prepare, distribute, and serve food to residents. Request clarification from the dietary supervisor/manager or qualified dietitian concerning the following:

- What is the facility's practice for dealing with employees who come to work with symptoms of contagious illness (e.g., coughing, sneezing, diarrhea, vomiting) or open wounds;
- How does the facility identify problems with time and temperature control of PHF/TCS foods and what are the processes to address those problems;
- Whether the facility has, and follows, a cleaning schedule for the kitchen and food service equipment; and
- If there is a problem with equipment, how staff informs maintenance and follows up to see if the problem is corrected.

## **3. Record Review**

In order to investigate identified food safety concerns, review supporting data, as necessary, including but not limited to:

- Any facility documentation, such as dietary policies and procedures, related to compliance with food sanitation and safety. Determine if the food service employees have received training related to such compliance;

- Utilizes proper hand washing and personal hygiene practices to prevent food contamination; and
- Maintains equipment and food contact surfaces to prevent food contamination.

If not, cite at Tag F371.

### **Noncompliance for F371**

After completing the Investigative Protocol, analyze the data in order to determine whether noncompliance with the regulation exists. Noncompliance for Tag F371 may include, but is not limited to, failure to do one or more of the following:

- Procure, store, handle, prepare, distribute, and serve food in accordance with the standards summarized in this guidance;
- Maintain PHF/TCS foods at safe temperatures, at or below 41 degrees F (for cold foods) or at or above 135 degrees F (for hot foods) except during preparation, cooking, or cooling, and ensure that PHF/TCS food plated for transport was not out of temperature control for more than four hours from the time it is plated;
- Store raw foods (e.g., meats, fish) in a manner to reduce the risk of contamination of cooked or ready-to-eat foods;
- Cook food to the appropriate temperature to kill pathogenic microorganisms that may cause foodborne illness;
- Cool food in a manner that prevents the growth of pathogenic microorganisms;
- Utilize proper personal hygiene practices (e.g., proper hand washing and the appropriate use of gloves) to prevent contamination of food; and
- Use and maintain equipment and food contact surfaces (e.g., cutting boards, dishes, and utensils) to prevent cross-contamination.

### **Potential Tags for Additional Investigation**

During the investigation of 42 CFR §483.35(i)(1)(2), the surveyor may have identified concerns related to these requirements. The surveyor should investigate these requirements before determining whether noncompliance may be present. The following are related outcome, process, and structure requirements that may be considered:

- 42 CFR 483.25(g)(2), F322, Nasogastric Tubes
  - o Determine if residents have experienced nausea, vomiting, diarrhea, or other gastrointestinal symptoms as a result of the failure to store, handle, administer, or remove and discard tube feeding solutions in a safe and sanitary manner.

- 42 CFR 483.70(o) (2) (i) (ii), F520, Quality Assessment and Assurance
  - o Determine whether the quality assessment and assurance committee seeks and reviews concerns related to foodborne illness, and food safety and sanitation to develop and implement appropriate actions to correct identified quality deficiencies when indicated.

#### **IV. DEFICIENCY CATEGORIZATION (PART IV, APPENDIX P)**

Once the survey team has completed its investigation, analyzed the data, reviewed the regulatory requirements, and determined that noncompliance exists, the team must determine the severity of each deficiency, based on the resultant effect or potential for harm to the resident.

The key elements for severity determination for Tag F371 are as follows:

**1. Presence of harm/negative outcome(s) or potential for negative outcomes because of the presence of unsanitary conditions.** Actual or potential harm/negative outcome for Tag F371 may include, but is not limited to:

- Foodborne illness; or
- Ingestion or potential ingestion of food that was not procured from approved sources, and stored, prepared, distributed or served under sanitary conditions.

**2. Degree of harm (actual or potential) related to the noncompliance.** Identify how the facility's noncompliance caused, resulted in, allowed or contributed to the actual or potential for harm.

- If harm has occurred, determine if the harm is at the level of serious injury, impairment, death, compromise, or discomfort; or
- If harm has not yet occurred, determine the potential for serious injury, impairment, death, or compromise or discomfort to occur to the resident.

**3. The immediacy of correction required.** Determine whether the noncompliance requires immediate correction in order to prevent serious injury, harm, impairment, or death to one or more residents.

The survey team must evaluate the harm or potential for harm based upon the following levels of severity for Tag F371. First, the team must rule out whether Severity Level 4, Immediate Jeopardy to a resident's health or safety exists by evaluating the deficient practice in relation to immediacy, culpability, and severity. (Follow the guidance in Appendix Q.)

Examples of avoidable actual or potential resident outcomes that demonstrate severity at Level 3 may include, but are not limited to:

- Outbreak of nausea and vomiting occurs in the facility related to the inadequate sanitizing of dishes and utensils; and
- Episode of food poisoning occurs because facility had an event in which tuna, chicken, and potato salads served in bulk were not kept adequately chilled and were still left out for eating after 5 hours.

**Severity Level 2 Considerations: No Actual Harm with Potential for More Than Minimal Harm that is Not Immediate Jeopardy**

Severity Level 2 indicates noncompliance that results in a resident outcome of no more than minimal discomfort and/or has the potential to compromise the resident's ability to maintain or reach his or her highest practicable level of well-being. The potential exists for greater harm to occur if interventions are not provided.

As a result of the facility's noncompliance, the potential for food contamination and/or growth of pathogenic microorganisms exists. Examples of avoidable actual or potential resident outcomes that demonstrate severity at Level 2 may include, but are not limited to:

- Food service workers sliced roast pork on the meat slicer. The meat slicer was not washed, rinsed, and sanitized after usage. The facility failed to educate and train staff on how to clean and sanitize all kitchen equipment;
- During the initial tour of the kitchen, two food service workers were observed on the loading dock. One was smoking and the other employee was emptying trash. Upon returning to the kitchen, they proceeded to prepare food without washing their hands; and
- Upon inquiry by the surveyor, the food service workers tested the sanitizer of the dish machine, the chemical rinse of the pot-and-pan sink, and a stationary bucket used for wiping cloths. The facility used chlorine as the sanitizer. The sanitizer tested less than 50 ppm in all three locations. Staff interviewed stated they were unaware of the amount of sanitizer to use and the manufacturer's recommendations to maintain the appropriate ppm of available sanitizer.

**Severity Level 1 Considerations: No Actual Harm with Potential for Minimal Harm**

The failure of the facility to procure, prepare, store, distribute and handle food under sanitary conditions places this highly susceptible population at risk for more than minimal harm. Therefore, Severity Level 1 does not apply for this regulatory requirement.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185389	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  07/13/2010
NAME OF PROVIDER OR SUPPLIER  EDGEMONT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 329 WEBSTER AVENUE CYNTHIANA, KY 41031	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
K 000	INITIAL COMMENTS  A Life Safety Code survey was initiated and concluded on 07/13/2010. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was a "E".	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure hazardous areas were protected according to NFPA standards.  The findings include:  Observation on 07/13/10 at 11:26 AM, revealed that the maintenance shop area had a door which contained a louver and a screen. The Maintenance Director was present during the observation.	K 029		

**RECEIVED**  
AUG 11 2010  
BY: \_\_\_\_\_

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Deborah Zeck

Administrator

8-11-10

Any deficiency statement appearing with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 029	<p>Continued From page 1</p> <p>Interview on 07/13/10 at 11:26 AM, with the Maintenance Director, revealed the facility believed they meet the requirements for the protection of the Hazardous area.</p> <p>Reference: NFPA 101(2000 edition)</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ul style="list-style-type: none"> <li>(1) Boiler and fuel-fired heater rooms</li> <li>(2) Central/bulk laundries larger than 100 ft<sup>2</sup> (9.3 m<sup>2</sup>)</li> <li>(3) Paint shops</li> <li>(4) Repair shops</li> <li>(5) Soiled linen rooms</li> <li>(6) Trash collection rooms</li> <li>(7) Rooms or spaces larger than 50 ft<sup>2</sup> (4.6 m<sup>2</sup>), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction</li> <li>(8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard.</li> </ul>	K 029			

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K 029	Continued From page 2	K 029			
K 050 SS=D	<p>Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure fire drills were conducted according to NFPA standards.</p> <p>The findings include:</p> <p>During record review on 07/13/10 at 10:50 AM, it was determined the facility had conducted fire drills for night shift at the same time for the last two (2) quarters. The drills were conducted at 7:00 PM. Fire drills should be conducted under various conditions and at unexpected times. The Maintenance Director was present during record review.</p> <p>Interview on 07/13/10 at 10:50 AM, with the Maintenance Director, revealed the fire drills were</p>	K 050			

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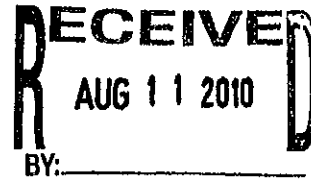
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K 050	Continued From page 3 being conducted at that time because of his work schedule.  Reference: NFPA 101 (2000 edition)  19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms.  Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050			
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure means of	K 072			

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185389</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/13/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>EDGEMONT HEALTHCARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>323 WEBSTER AVENUE CYNTHIANA, KY 41031</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 072	<p>Continued From page 4</p> <p>egress was continuously free of all obstructions according to NFPA standards.</p> <p>The findings include:</p> <p>Observation, on 07/13/2010 at 11:42 AM, revealed the 300 hall corridor contained a lift and linen cart which were not in use and that was unattended. Further observation, on 07/13/2010 at 12:22 PM, revealed the lift and linen cart were still unattended and not in use. These items would pose a risk to residents that were trying to use the handrails or to occupants of the building trying to access exits in an emergency. The Maintenance Director was present during the observations.</p> <p>Interview, on 07/13/2010 at 12:22 PM, with the Maintenance Director, revealed lifts and linen carts were routinely left in the hallway and the facility was under the impression that if the carts were placed to one side of the hallway they were meeting code.</p> <p>Interview on 07/13/2010 at 12:45 PM, with The Owner of the facility, revealed the facility had moved the linen carts to the hallways due to a previous health survey deficiency, and she thought the facility was meeting the requirements for the Life Safety Code.</p>	K 072			

**LIFE SAFETY PLAN OF CORRECTION (K TAGS)**



**Plan of Correction for K029**

**NFPA 101 Life Safety Code Standard**

- #1- Area identified has been assured that hazardous/flammable liquids/chemicals have been removed from the maintenance shop area as of 7/16/2010, and chemicals placed behind appropriate fire rated doors for storage.
- #2- Only area identified as having hazardous substance storing said materials without having appropriate door for flammable fire hazards. No residents were affected by said practice.
- #3/#4- Maintenance personnel and general all staff meeting (housekeeping, Laundry, Nursing, etc) given on several dates: 7/19/10, 7/29/10 given by Maintenance Director, Administrator, Director of Nursing, and Corporate Executive Director to assure compliance of appropriate storage of chemicals/materials. QA meeting held on 8/3/2010 and was addressed in addition with Dept managers present along with person responsible for compliance. Maintenance Director/designee shall audit room at least weekly times 90 days and will include/document any noted issues on QA form sheet for Administrator to assure additional education/in-services given as needed. In addition, Administrator/designee shall audit area on weekly basis and include on QA form to show compliance times 90 days and will include issues at monthly QA meetings and Safety Committee meetings x 90 days.

**Maintenance Director responsible for compliance.**

**Date of Compliance: 8/3/10**

**Plan of Correction for K050**

**NFPA 101 Life Safety Code Standard**

- #1-Fire drills were conducted on 8/5/10 at 10:00 am and on 8/10/10 at 5:30 am by the Maintenance Director/designee. The fire drill times have been recorded on the fire drill critique form.
- #2-Fire drills were given on both shifts prior to survey but evening shift were given at the same time but will vary in times after date of exit even though having on both shifts. No residents were affected by said practice.
- #3/4- Administrator and owner conducted in-service with Maintenance Director and designee on 7/13/10 to assure compliance with fire drill times. General All staff meeting held on 7/29/2010 regarding importance of variance for fire drills and performance. QA meeting was held on 8/3/10 and was addressed in addition with Dept. Managers present along with person responsible for compliance. Maintenance Director/Designee shall record fire drill times on fire drill critique forms. Administrator/designee will audit forms to assure compliance with QA meetings times 90 days. Issues related to compliance with fire drills will be monitored at the monthly QA meetings x 90 days.

**Maintenance Director responsible for compliance**

**Date of Compliance: 8/3/2010**

**Plan of Correction for K072**  
**Life Safety Code Standard**

# 1- Hoyer lift being stored out of hallway when not in use for more than 30 minutes of use. Linen carts being stored in appropriate locations off halls when not in use/more than 30 min after staff perform rounds requiring need of clean linens.

#2-No residents were affected by said practice as no falls/or fires occurred during said practice.

#3/4- In-service conducted on falls prevention 7/16/10 by Facility Administrator/Environmental Director to general nursing staff as well as facility conducted a general all staff meeting (including housekeeping, laundry, nursing, dietary, etc.) on July 29, 2010 informing staff to assure an environment free of hazards including removing the Hoyer lift and linen carts from the hallways when not in use for more than 30 minutes. QA meeting was held with (QI members) Dept. heads on 8/3/10 to discuss issues related to a hazard free environment including removing Hoyer lift and linen carts from hallways. Dept. heads will monitor hallways at least 3 times per week and shall document concerns on QI rounds sheet if noting items sitting out more than allotted times frames and shall be discussed at following stand up meeting times 30 days to assure compliance/concerns addressed. Any noted issues will be documented on the QA round sheet for the Administrator to assure any additional education/in-services are given as needed. In addition Administrator/designee shall monitor hallways on a weekly basis and include on a QA form to show compliance x 60 days and will include issues at monthly QA meetings.

**Maintenance Director responsible for compliance**  
**Date of Compliance: 8/3/2010**

In addition to 8/3/2010 QA meeting which included deficient practice and discuss other possible complications, resolving current issues and auditing for compliance with both IDT team and Medical Director/Administrator present, facility will perform monthly formal QA meetings times 90 days to assure ongoing compliance, auditing performance and also to prepare for MDS 3.0 transformation. Information shall be discussed regarding findings of audits, MDS completions with transmissions performed for that month to correlated with MDS completed/due by Executive Director/designee in addition to CPC as noted in above paragraph.

**CPC and Administrator responsible for QA compliance**  
**Date of compliance: 8/28/2010**

#### **LIFE SAFETY PLAN OF CORRECTION (K TAGS)**

##### **Plan of Correction for K029** **NFPA 101 Life Safety Code Standard**

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#2- Only area identified as having hazardous substance storing said materials without having appropriate door for flammable fire hazards. No residents were affected by said practice.  
#3/#4- Maintenance personnel and general all staff meeting (housekeeping, Laundry, Nursing, etc) given on several dates: 7/19/10, 7/29/10 given by Maintenance Director, Administrator, Director of Nursing, and Corporate Executive Director to assure compliance of appropriate storage of chemicals/materials. QA meeting held on 8/3/2010 and was addressed in addition with Dept managers present along with person responsible for compliance. Maintenance Director/designee shall audit room at least weekly times 90 days and will include/document any noted issues on QA form sheet for Administrator to assure additional education/in-services given as needed. In addition, Administrator/designee shall audit area on weekly basis and include on QA form to show compliance times 90 days and will include issues at monthly QA meetings and Safety Committee meetings x 90 days.

**Maintenance Director responsible for compliance.**  
**Date of Compliance: 8/4/10**

##### **Plan of Correction for K050** **NFPA 101 Life Safety Code Standard**

#1-Fire drills were conducted on 8/5/10 at 10:00 am and on 8/10/10 at 5:30 am by the Maintenance Director/designee. The fire drill times have been recorded on the fire drill critique form.  
#2-Fire drills were given on both shifts prior to survey but evening shift were given at the same time but will vary in times after date of exit even though having on both shifts. No residents were affected by said practice.  
#3/4- Administrator and owner conducted in-service with Maintenance Director and designee on 7/13/10 to assure compliance with fire drill times. General All staff meeting held on 7/29/2010 regarding importance of variance for fire drills and performance. QA meeting was held on 8/3/10 and was addressed in addition with Dept. Managers present along with person responsible for compliance. Maintenance

Director/Designee shall record fire drill times on fire drill critique forms. Administrator/designee will audit forms to assure compliance with QA meetings times 90 days. Issues related to compliance with fire drills will be monitored at the monthly QA meetings x 90 days.

**Maintenance Director responsible for compliance**  
**Date of Compliance: 8/4/2010**

**Plan of Correction for K072**  
**Life Safety Code Standard**

# 1- Hoyer lift being stored out of hallway when not in use for more than 30 minutes of use. Linen carts being stored in appropriate locations off halls when not in use/more than 30 min after staff perform rounds requiring need of clean linens.

#2-No residents were affected by said practice as no falls/or fires occurred during said practice.

#3/4- In-service conducted on falls prevention 7/16/10 by Facility Administrator/Environmental Director to general nursing staff as well as facility conducted a general all staff meeting (including housekeeping, laundry, nursing, dietary, etc.) on July 29, 2010 informing staff to assure an environment free of hazards including removing the Hoyer lift and linen carts from the hallways when not in use for more than 30 minutes. QA meeting was held with (QI members) Dept. heads on 8/3/10 to discuss issues related to a hazard free environment including removing Hoyer lift and linen carts from hallways. Dept. heads will monitor hallways at least 3 times per week and shall document concerns on QI rounds sheet if noting items sitting out more than allotted times frames and shall be discussed at following stand up meeting times 30 days to assure compliance/concerns addressed. Any noted issues will be documented on the QA round sheet for the Administrator to assure any additional education/in-services are given as needed. In addition Administrator/designee shall monitor hallways on a weekly basis and include on a QA form to show compliance x 60 days and will include issues at monthly QA meetings.

**Maintenance Director responsible for compliance**  
**Date of Compliance: 8/4/2010**